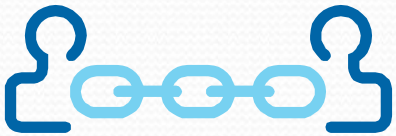
Continuity of Care

Following State Hospital Discharge

CenterPoint Human Services

People In Partnership Making A Difference

Care Coordination



Care Coordination is the art of working around barriers and developing ways of connecting people in need with services that can support them on their path to recovery.

Successful care coordination requires an intimate knowledge of several systems, problem solving skills, and an ability to engage interpersonally.

The role of Care Coordination has evolved to include Hospital Liaison, Homeless Shelter Liaison, Jail Liaison, Cost and Risk reduction, Medical/Behavioral Health Integration, and Peer Support.

Starting Points

DMH/DD/SAS Letter – Sept. 30, 2008

- Indicated a failure of CenterPoint to ensure follow-up care for State Hospital Discharges beyond a floating state average for SFY08 Qs 3&4

- Invoked provisions of G.S. 112C-115.4(d) which allow for
  - Focused Technical Assistance to the LME
  - Removal of Care Coordination from the LME

- Required a Plan of Action to be submitted to DMH by Oct. 10, 2008.

The Way We Were

- At the time of the letter (SFY09 Q1) The percentage of State Hospital discharges receiving aftercare within 7 days of discharge was 27% (51% within 30 days).

Understanding the Numbers

The Data:

- Based upon Medicaid and IPRS (indigent care state funds) paid claims data for MH/DD/SA services rendered.
- Population defined by indicated county of discharge from State Psychiatric Facilities for eligible discharge (excludes transfers, correctional, and medical discharges).
- Receiving county is responsible regardless of residence prior to admission to the hospital.

Understanding the Numbers

Limitations of the Data:

- “Paid Claims” data includes only what has been successfully billed and paid; not what was rendered.
- Medicaid claims are valid for submission for payment for up to 12 months from the date of service.
- State *Quarterly Progress Indicator Reports* are produced 60 days following the end of each quarter, thus not capturing all eligible claims.
- Some claims for services delivered will inevitably fail to become “paid claims” due to technical issues, authorization issues, and failure to submit for payment.

Aftercare Challenges

Consumer Choice

- Along with the right to choose one's provider of services comes the right to refuse services all together.

Transportation

- Transportation is not billable under any service definition, so getting people to their aftercare appointments is a challenge.

Access to Medications

- Indigent medication programs exist through pharmaceutical companies for some drugs, but the process is involved and takes time. Hospitals provide a limited supply at discharge.

Appointment Lag

- Delays in scheduling results in a drop in adherence rates.

The Response

State Hospital Aftercare Restructured

CenterPoint Human Services

People In Partnership Making A Difference

Multi-Level Solutions

CenterPoint has put into place an interactive, multi-level system to ensure continuity of care following hospitalization. In doing so we put resources at hand to work to empower consumers in their recovery process.

Multi-Level Solutions

- Partnership with Daymark Recovery Services to provide a day-of-discharge clinic appointment.
- “Check-in” appointment assures connection with the system while preserving consumer choice of provider.

Multi-Level Solutions

- Developed alternate discharge transport to support Sheriffs' Departments.
- Transport automatically scheduled prior to discharge.
- Transport is direct to first appointment as well as "home" from the clinic.

Multi-Level Solutions

- Developed alternative service definition for Peer Support.
- Funded Peer Support positions to “ride-along” with discharge transport as well as on-site at the discharge clinic.
- Provides support, guidance, WRAP planning upon discharge.

Multi-Level Solutions

- Developed Patient Assistance and Indigent Medications Program.
- Partnership with Forsyth County Public Health Pharmacy.
- Enrolls consumers in Patient Assistance Programs offered by drug manufacturers.
- Provides low-cost or free of charge medications for indigent care.
- Recaptures and redistributes sample and discarded medications.
- Provided $4.1 Million in free medications in SFY10.
- 3 FTE positions to support these programs.

Multi-Level Solutions

clinic transport support meds *crisis*

- Developed a program for automatic dispatch of Mobile Crisis Management Team in response to any missed State Hospital Discharge Appointment.
- Allows for rapid response to prevent disruption of treatment.
- Seeks to re-engage individuals in community treatment.
- Supplemented with calls, letters and home visits from providers and LME staff.

Behind the Scenes

High Cost / High Risk Tracking

- Developed a system which automatically identifies and tracks consumers in the system who are High Cost and/or High Risk.
- Individual staff assigned for intensive monitoring and engagement.
- Integrated electronic documentation allows efforts to be automatically shared internally with LME Jail, Hospital and Shelter Liaisons as well as with ACCESS Line clinicians and Utilization Management Staff.
- Multi-Level clinical review processes to ensure that all possible strategies are being considered.

Behind The Scenes

State Hospital Peer Support

- Initiated a pilot program for incorporating LME Peer Support Specialist staff on-site at the State-Hospital Community Transition (Long-Term) Unit.
- Certified Peer Support Specialist is on-site 2 days weekly to provide face-to-face supports to Long-Term patients.
- PSS also teaches WRAP classes as part of the discharge readiness curriculum at the State Hospital.
- All efforts are documented electronically so that input can be used to supplement Care Coordination and Treatment Planning efforts.
- CPHS PSS Pilot recently recognized by CRH in quarterly publication.

Behind The Scenes

Care Coordination Staffing

- Care Coordination Manager
- Intellectual and Developmental Disabilities Care Coordinator
- Child and Adolescent Care Coordinator
- Substance Abuse and Homelessness Care Coordinator
- Adult MH/SA Hospital Liaison
- 2 RN Community Care Network BH/Medical Integration Staff
- 2 Certified Peer Support Specialists (part-time)

Plus

- 2 Law Enforcement / Jail Liaisons in the Community Relations Department.
- Support Staff

Results

Post-Discharge Continuity of Care

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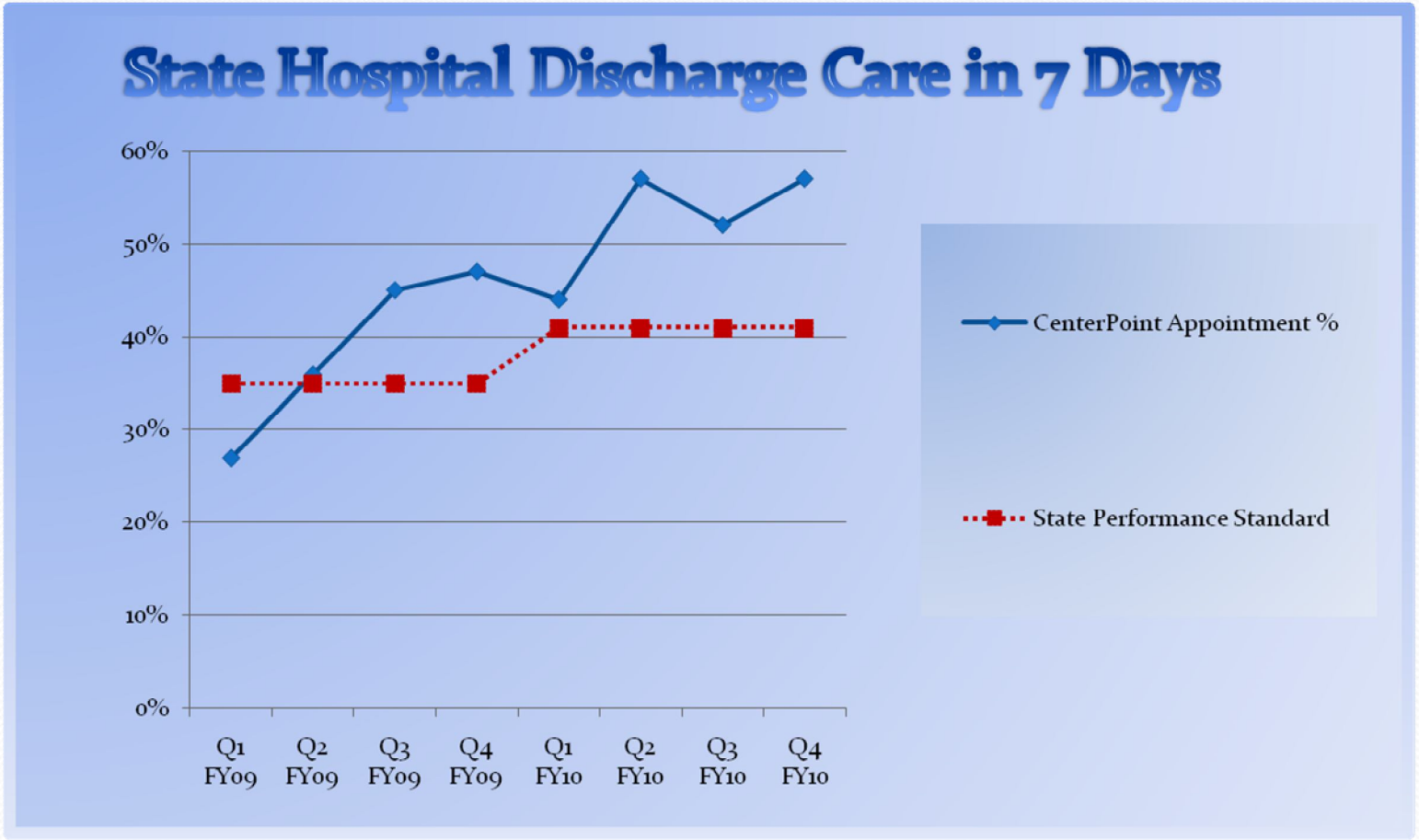
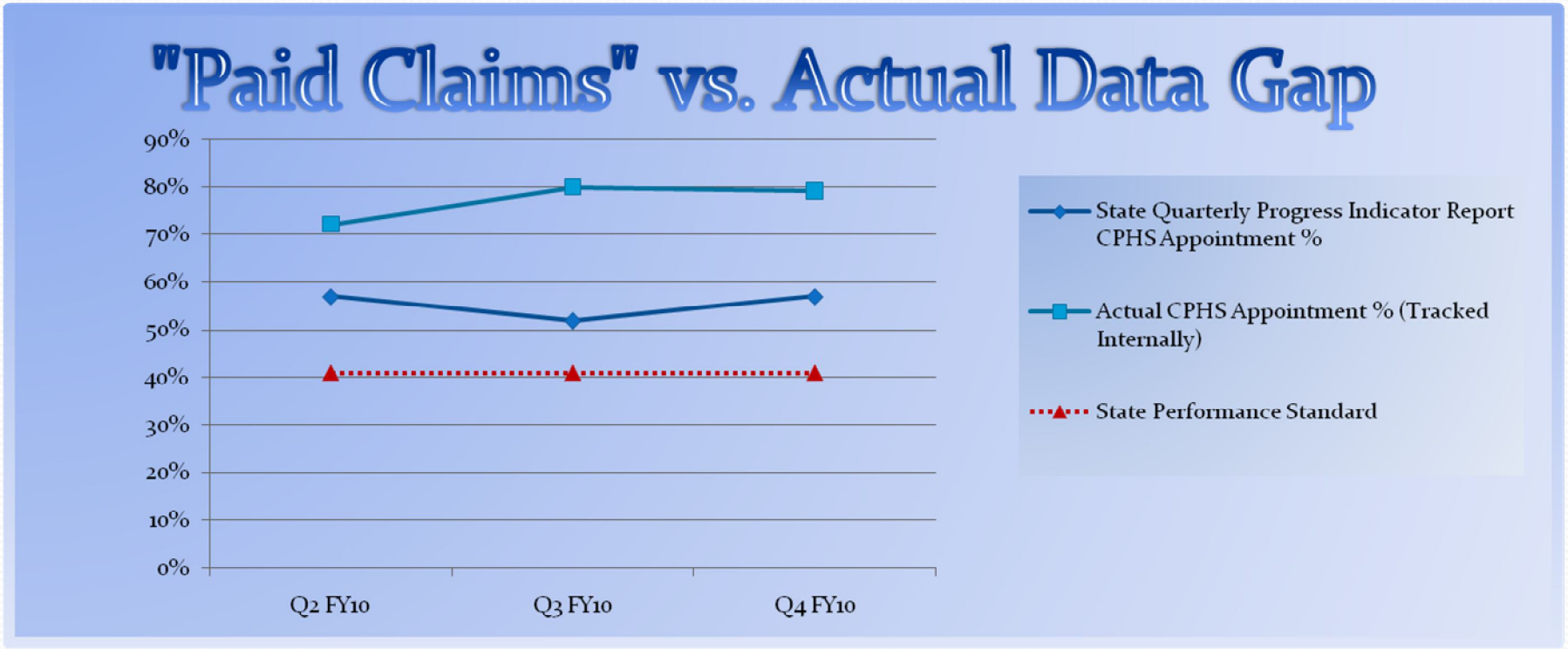
The Results



211% improvement over 2 years

The Results



The gap between "Paid Claims" data and actual percentages of individuals receiving aftercare (avg. 72% of actual).

* Continued improvement: October 2011 – Actual = 92.3%

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Questions?